The Commonwealth of Massachusetts

Executive Office of Health and Human Services
Department of Public Health
Division of Health Professions Licensure
Board of Registration in Nursing
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Substance Abuse Rehabilitation Program
Nursing Supervisor Report

Name of SARP Participant: _____
License Type and No._____
Participant's Date of Hire:_____

Supervisor's Name & Title:_____
Work Telephone No.:_____**Email:**_____
License Type & No.:_____

Employer Name and Address: _____
_____

Time period covered by this supervision report (start and end date): _____

Rate the following and explain as necessary.

Attendance
In the previous 3 months how many days has the Participant been absent? ___
Did the Participant provide you with documented justification to excuse the absence(s)? YES NO _____ If so, please briefly describe:
Did the Participant require any administrative action as a result of these absences? If yes, please explain:
Tardiness
In the previous 3 months the Participant has been tardy how many times?__
Did the Participant provide you with documented justification for this tardiness? YES NO _____ If so, please briefly describe:

Did the Participant require any administrative action as a result of this tardiness?
If yes, please explain:

Nursing Practice

In the previous 3 months, has the Participant maintained appropriate professional interactions with:

1. Peers: YES NO ____
2. Supervisors: YES NO __
3. Patients/residents: YES NO _
4. Families/others: YES NO _

Please describe:

In the previous 3 months, has the Participant:

1. Demonstrated overall expectations of the nursing role: YES NO _____
2. Followed policies and procedures: YES NO _____
3. Demonstrated accuracy in documentation: YES NO _____
4. Exercised reasonable clinical judgment: YES NO _____
5. Sought supervision when necessary: YES NO _____
6. Demonstrated reasonable problem-solving abilities: YES NO _____
7. Completed assignments on time: YES__ NO _____
8. For Participants with medication administration privileges;
    a. has the Participant administered medications without incident: YES__ NO__
    b. has there been any concern (i.e. discrepancy, failure to reconcile) with the Participant's handling, administration and wastage of controlled substances. YES__ NO__

Please describe:

ADDITIONAL COMMENTS

(If needed, please attach additional sheet and indicate below)

********** Please call SARP Staff at (617) 973-0904 to discuss any concerns or for clarification regarding the Participant.

I attest that I have read and understand the Participant's Consent Agreement for SARP Participation (CASP) and Amendment(s), including all program requirements and practice restrictions.

SUPERVISOR'S SIGNATURE:_____DATE SIGNED__ _____